Medicare & You
The knowledge to make good decisions

Worksheet for Comparing Medicare Health Plans

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Health Care Financing Administration
The Federal Medicare Agency

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How to Use this Worksheet:

Write the plan names in the blocks with the word "Plan." Use the rest of the blocks under each plan to fill in the answers to each question for that plan.

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Introduction

In Medicare, you may be able to get your health care coverage from:

The Original Medicare Plan

The Original Medicare Plan is also known as "fee-for service." This plan, offered by the federal government, is available nationwide. You may go to any doctor, specialist, or hospital that accepts Medicare. You are usually charged a fee for each health care service or supply you get.

Or, you can get your coverage through another Medicare health plan under Medicare + Choice. Congress created the Medicare + Choice program to let more private insurance companies offer coverage to people in Medicare. Some of your choices may include:

A Medicare managed care plan, like an HMO

A Medicare managed care plan, sometimes called an HMO, is a health plan offered by private insurance companies. In most managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan.

A Medicare Private Fee-for-Service plan

A Private Fee-for-Service plan is a new type of health care plan that is available in some areas of the country. It is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan, which is offered by the federal government. If you have a Private Fee-for-Service plan, you may go to any doctor or hospital that accepts the plan's payment.

You may have heard about Medicare Medical Savings Accounts (MSAs). At the time this book was printed, no private insurance companies had decided to offer MSAs to people with Medicare. To find out if MSAs have become available in your area or to get a booklet about this type of plan, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

No matter how you get your Medicare benefits, you are still in the Medicare program. In every Medicare health plan, you get all the Medicare Part A and Part B covered services.

Introduction

Medicare health plans may have differences among them, such as:

- cost
- choice of providers
- extra benefits
- convenience
- quality
- complaints

Use this worksheet to ask the questions that are important to you and compare the answers. The information you get will help you compare plans and make the health plan choice that is right for you. Write in the plan names and the answers from each plan to keep a record.

Each worksheet section begins with important information about the differences among the Original Medicare Plan, Medicare managed care plans, and Private Fee-for-Service plans.

You can get up-to-date information about the Medicare health plans available in your area by:

- Looking at www.medicare.gov on the Internet. Your local library or senior center may be able to help you find this information on their computers.
- Calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).
- Calling the State Health Insurance Assistance Program in your area. The number for your state will be listed in your copy of *Medicare & You,* or can be found at www.medicare.gov on the Internet.

Cost

In all Medicare health plans, you must pay the monthly Part B premium.

In the Original Medicare Plan, you must pay additional costs such as hospital deductibles, coinsurance, and copayments. The Original Medicare Plan does not pay for outpatient prescription drugs, with only a few exceptions. You may be able to cover these out-of-pocket costs by buying a Medigap policy or by joining one of the other Medicare health plans.

The additional costs in Medicare managed care plans and Private Fee-for-Service plans depend on whether the plan charges a monthly premium in addition to your monthly Part B premium of $45.50 in 2000, how much the plan decides you must pay for each doctor visit (copayment), and, for Private Fee-for-Service plans, whether providers are allowed to bill extra. Costs vary from plan to plan.

In most Medicare managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan. Some managed care plans offer a point-of-service option. This option allows you to go to other doctors and hospitals, who are not part of the plan. Most of the time, this option costs you more.

All Medicare managed care plans must allow you to get emergency care whenever you need it from any provider in the United States. You do not need permission from your primary care doctor first. Your plan must pay for emergency care. In a Medicare managed care plan, you get urgently needed care from your primary care doctor. However, if you are out of the plan's service area and cannot wait until you return home, your plan must pay for urgently needed care.

In Private Fee-for-Service plans, you can go to any doctor or hospital that accepts the terms of the plan's payment. You pay and the insurance company pays a fee for each doctor visit or service you get. The insurance company, rather than the Medicare program, decides how much it pays, and how much you pay, for the services you get.

Cost

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the plan and ask...	**Plan:**	**Plan:**	**Plan:**
Will I have to pay a monthly premium in addition to my monthly Part B premium?			
Will I be charged copayments for doctor visits?			
Does the plan pay for prescriptions? How much?			
Does the plan have maximum amounts it will pay for different services? How much?			
Will I have to pay a deductible or coinsurance for inpatient hospital services, home health, or skilled nursing facility services?			

Cost

If you are in a Medicare managed care plan, call the plan and ask…	**Plan:**	**Plan:**	**Plan:**
Will I have to pay more if I use a doctor or hospital outside the plan? How much?			

If you are in a Private Fee-for-Service plan, call the plan and ask….	**Plan:**	**Plan:**	**Plan:**
Does the plan set limits on what doctors and hospitals charge me?			
Does the plan have any "pre-notification" requirements (for example, a requirement that I notify the plan of any planned inpatient admissions)?			

Doctors, Hospitals, and Other Health Care Professionals

In the Original Medicare Plan, and the Original Medicare Plan with a Medigap policy, you may use any provider who accepts Medicare. In Private Fee-for-Service plans, you may use any provider who accepts the terms of the plan's payment.

In most Medicare managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan. Generally, you can only see a specialist (like a cardiologist) when you get a referral, which means your primary care doctor says it is OK to go. If you like your current doctor and want to continue seeing him or her after you join a plan, first ask if he or she belongs to any of the plans you are thinking of joining.

If you are in a Medicare managed care plan, call the plan and ask....	**Plan:**	**Plan:**	**Plan:**
Is there a selection of the doctors, health professionals, and hospitals that I might need?			
Can I see the same doctor on most visits?			
Can I change doctors once I am in the plan?			
What's the plan's policy if it doesn't have the type of specialist I need?			

If you are in a Medicare managed care plan, call the doctor and ask....	**Plan:**	**Plan:**	**Plan:**
Are my doctors in the plan?			
Can I get the doctor I want? Is he/she accepting new patients under that plan?			

Doctors, Hospitals, and Other Health Care Professionals

If you are in a Private Fee-for-Service plan, call the doctor and ask...	**Plan:**	**Plan:**	**Plan:**
Does the doctor know and accept the terms of the plan's payment?			
Is the doctor taking new patients?			

Extra Benefits

The types of services described in this section are in addition to Medicare Part A and Part B covered services. Medigap policies, Medicare managed care plans, and Private Fee-for-Service plans often have extra benefits. For example, in Private Fee-for-Service plans, you may be able to get coverage for additional days in the hospital.

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the plan and ask: Does the plan cover/provide...	**Plan:**	**Plan:**	**Plan:**
Routine physicals?			
Eye exams, glasses, contacts?			
Hearing exams and hearing aids?			
Dental exams/treatments?			
Programs that focus on helping members with specific, chronic conditions such as asthma, diabetes, or heart conditions?			
Programs that help with needs like respite care, care giver services, and other social services?			
Wellness programs and classes that help members lose weight, eat properly, stop smoking, or exercise appropriately? Is there any charge?			
Other extra benefits I may be interested in:			

Prescription Drugs - An Important Extra Benefit

The Original Medicare Plan does not pay for outpatient prescription drugs, with only a few exceptions. Some Medigap policies help with the cost of prescription drugs, and some Medicare managed care plans and Private Fee-for-Service plans may cover some of the cost for prescription drugs.

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the plan and ask:	**Plan:**	**Plan:**	**Plan:**
Does the plan cover the drugs I use?			
May I use my regular pharmacy?			
Are mail-order prescriptions available?			
What is the annual or quarterly dollar limits on prescription drug coverage?			
Will I have to pay more if I prefer to use brand name instead of generic drugs?			
Is there a maximum out-of-pocket cost for prescription drugs? What is it?			
Does the plan limit the prescription drugs it pays for to those on a list of drugs (called a formulary)?			

Convenience

Location, hours of operation, and similar details may be important to you. Call each plan to decide if it is convenient for you.

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the doctor or health care provider and ask...	**Plan:**	**Plan:**	**Plan:**
Are the hours and location of doctors, clinics, and other health care providers convenient?			
Are the doctors' offices, labs, and other services convenient?			

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the plan and ask...	**Plan:**	**Plan:**	**Plan:**
How fast can I be seen for urgent (non-emergency) care?			
Is there a telephone hotline for medical advice?			

All Medicare doctors must be licensed in their state. Medicare certifies hospitals, nursing homes, and suppliers. Medicare also requires that Medicare managed care plans have quality assurance programs to get a Medicare contract. Medicare managed care plans and Private Fee-for-Service plans must meet standards set by state and federal governments.

Beyond these basic standards, the quality of care in plans may vary. Three main types of information will tell you about the quality of care in a Medicare managed care plan. Note: Quality and disenrollment information is not available yet for Medicare Private Fee-for-Service plans because they are new.

1) Accreditation

This is an additional seal of approval by a private, independent, non-profit group, which evaluates a plan and gives it an official status based on that evaluation. Organizations that accredit Medicare managed care plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and the American Accreditation Healthcare Commission.

2) Quality information

Quality is how well the plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way for the right person—and getting the best possible results. Medicare has quality information for most Medicare managed care plans on more than 10 different quality measures. Quality measures include information from satisfaction surveys and performance measures.

- Satisfaction surveys. Medicare gets information from people like you in Medicare managed care plans about how satisfied they are with their plans. The survey used to collect this information is called the Medicare Satisfaction Survey, or the Medicare Consumer Assessment of Health Plans Survey (CAHPS)®. We use an outside research company to do the survey and report the results back to you.

2) Quality information (continued)

- Performance measures. Managed care plans keep track of some health care services they give you and report that care to Medicare. Medicare collects this information, sometimes called "performance measures," from the Health Plan Employer Data and Information Set (HEDIS)®. We carefully check this information before you see it.

3) Plan disenrollment information

This information shows the percentage of people with Medicare who chose to leave their Medicare managed care plan and the percentage who stayed during a year. The information is collected from Medicare managed care plans and does not include members who died, moved out of the area, were not eligible for managed care under Medicare, or whose plan decided not to serve people with Medicare in that area. Starting in 2001, you will be able to find out why people chose to leave a Medicare managed care plan.

Plan Quality and Disenrollment Information

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, ask...	**Plan:**	**Plan:**	**Plan:**
Your friends or relatives who are in the plan: Do they like the plan?			
Do they get the care they need when they need it?			
The plan: Is the plan accredited by an independent group?			
Where available: How does the plan compare on performance measures and consumer satisfaction surveys?			

For more information:

Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to get quality and other information about the Medicare health plans in your area, or look on the Internet at www.medicare.gov and click on Medicare Health Plan Compare.

Note: For some plans, quality and disenrollment information is not available because the plan is too new to be measured; the number of Medicare members was too small to report; or Medicare did not require the plan to report this information.

You have a right to appeal any decision about your Medicare services. If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare. In addition, Medicare has a contract with local PROs (Peer Review Organizations). You may call your PRO about quality of care concerns, filing an appeal or grievance (complaint), or questions about your rights as a hospital patient. For example, if you think the hospital is making you leave too soon, you may be able to stay in the hospital at no charge while the PRO reviews your case.

If you are in a Medicare managed care plan or Private Fee-for-Service plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must reach a decision within 72 hours. The plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, an independent organization that works for Medicare, not the plan, reviews the appeal.

If you are in a Medicare managed care plan, or a Private Fee-for-Service plan, call the plan and ask...	**Plan:**	**Plan:**	**Plan:**
Does the plan have a patient advocate/ombudsman to help members?			
What is the plan's record with appeals and grievances (complaints)?			

Other Questions You May Wish to Ask

Write your questions here:	Plan:	Plan:	Plan:

Benefit Period—The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period starts the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after 60 days, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance—The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Copayment—In some Medicare health plans, the amount you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5.00 or $10.00 for a doctor visit. Copayments may also be used for hospital outpatient services in the Original Medicare Plan later this year.

Deductible (Medicare)—The amount you must pay for health care before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

Medicare Managed Care Plan—These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Emergency Care—Care given for a medical emergency when you believe that your health is in serious danger—when every second counts.

Medicare Medical Savings Account Plan (MSA)—A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.

Medigap—A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Original Medicare Plan—A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved

amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Peer Review Organization (PRO)— Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service plans, and ambulatory surgical centers.

Primary Care Doctor— A doctor who is trained to give you basic care. This includes: being the first one to check on health problems; coordinating your preventive health care with other doctors, specialists, and therapists. In many Medicare managed care plans, you must see your primary care doctor before you can see any other health care provider.

Private Fee-For-Service Plan— A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Referral—A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care.

Urgently Needed Care—Care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening. Your primary care doctor generally provides urgently needed care if you are in a Medicare health plan other than the Original Medicare Plan. If you are out of your plan's service area for a short time and cannot wait until you return home, the health plan must pay for urgently needed care.

Notes

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